UNITED STATES of CARE

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Behind the Bill:

THE HIDDEN INJUSTICE OF HOSPITAL FACILITY FEES

About United States of Care

United States of Care (USofCare) is a non-partisan non-profit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people.

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As hospital acquisitions of private provider practices accelerate, hospitals are at the center of a massive market failure that is leading to reduced competition, increased prices, and ultimately unfair and inequitable consumer cost-sharing. In many ways, hospital facility fees – the charges hospitals levy in addition to professional services charges to cover the 24/7 operational costs of the hospital – and the growing affordability burden they are placing on patients are the symptoms of rampant provider consolidation. And facility fees are a considerable part of consumer cost sharing when it comes to hospital-related services.

More services are delivered in settings that are now hospital outpatient departments (HOPDs), even when those facilities are not actually part of a hospital campus. This means that following a hospital's acquisition of an outpatient facility, facility fees are increasingly attached to services that have very little to do with the everyday operation of hospitals and emergency departments. This places an unexpected and unfair financial burden on certain populations, particularly communities of color, rural communities, and communities who already experience disproportionate medical debt.

To address facility fees in ways that improve health equity, state and federal policymakers should consider the following:

1. Policymakers should **impose site, service, and billing specific limits on the use of hospital facility fees, using an equity lens to identify specific limits** on the types of services and sites to which facility fees may be applied and the circumstances under which hospitals can bill these services.
2. Regulators should **require hospitals to report data** on facility fees, including submitting a list of system-affiliated entities that charge facility fees, a listing of medical procedures subject to facility fees, the total revenue generated by facility fees, and the amount of cost-sharing people experience related to facility fees.
3. Facility fees should be **transparently disclosed** in patient notices.
4. Policymakers should ensure that facility fee protections and data requirements are **adequately enforced.**
5. Policymakers should **invest in research that evaluates the health equity implications** of hospital facility fees.

Introduction and Background

Hospital acquisitions of private provider practices are accelerating, and hospitals are at the center of a massive market failure that is leading to reduced competition, increased prices, and ultimately unfair and inequitable consumer cost-sharing. In many ways, hospital facility fees – the charges hospitals levy in addition to professional services charges to cover the 24/7 operational costs of the hospital – and the growing affordability burden they are placing on patients are the symptoms of rampant provider consolidation. And facility fees are a considerable part of consumer cost-sharing when it comes to hospital-related services.

As hospitals acquire outpatient clinics, more services are delivered in settings that are now hospital outpatient departments (HOPDs), even when those facilities are not actually part of a hospital campus. This means that following hospital acquisition, facility fees are increasingly attached to services that have very little to do with the everyday operation of hospitals and emergency departments. This places an unexpected and unfair financial burden on certain populations, particularly communities of color, rural communities, and other individuals who already face disproportionate medical debt.[1]

This report will highlight how increasing provider consolidation fuels financial exposure to hospital facility fees as more previously independent practices become hospital-affiliated sites of care. The report will zero in on the health equity implications these fees have based on race and ethnicity, income, the presence of a chronic or complex condition, and geography. Because of a dearth of data that stratifies facility fee exposure by site of service and by patient demographics, the report makes evidence-based assumptions about equity impacts using proxy data, such as hospital-related medical debt disparities. Finally, the report will set forth policy considerations to protect patients from inappropriate hospital facility fees.

What are facility fees and why do hospitals charge them?

"Facility fees" are essentially an overhead charge that hospitals levy on patients in addition to charges for specific services provided by medical professionals known as "professional fees." Hospitals contend that facility fees support staffing costs and equipment needed to provide emergency care and other services that are not directly tied to the care the patient received.[2] Unlike other provider settings, where the costs of professional services and any practice overhead are negotiated together with payers, a hospital facility fee is charged separately from the professional fee and is not attached to the underlying service provided. This means that a bill for emergency room services and a bill for a routine evaluation and management service provided in an on- or off-campus hospital department could incur the same facility fee charge. The addition of facility fees is one reason that many of the same services that can be safely delivered in a physician's office are more expensive when provided in a hospital setting.[3]

These fees often come as a surprise cost for consumers, in large part because they are increasingly attached to services not received in a hospital setting. As hospital acquisition of provider practices has surged in recent years, facility fees are increasingly showing up on bills for services provided in hospital outpatient settings.[4] These fees present a growing

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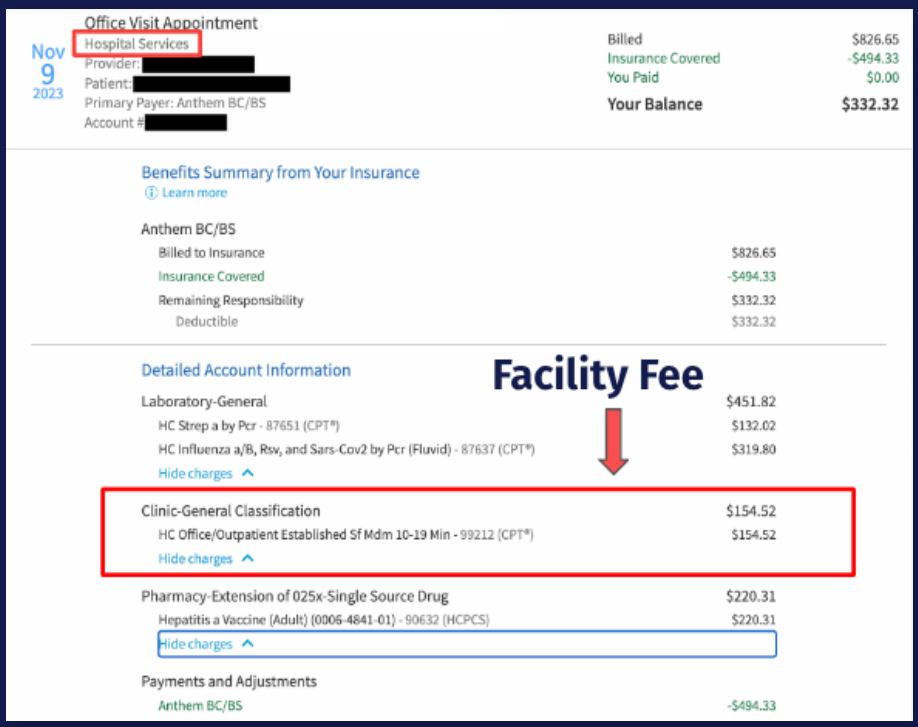
affordability burden for uninsured individuals because of their high cost. They are even challenging for consumers with insurance, as insurers are increasingly passing these fees, in addition to higher hospital professional service bills, along to consumers.[5] Hospitals argue that even in hospital outpatient settings, these facility fees are critical to supporting hospital infrastructure. However, as facility fees are attached to services not directly connected to hospital care, they begin to look more and more like a surprise bill which disproportionately harms communities already struggling with medical debt and health care affordability.



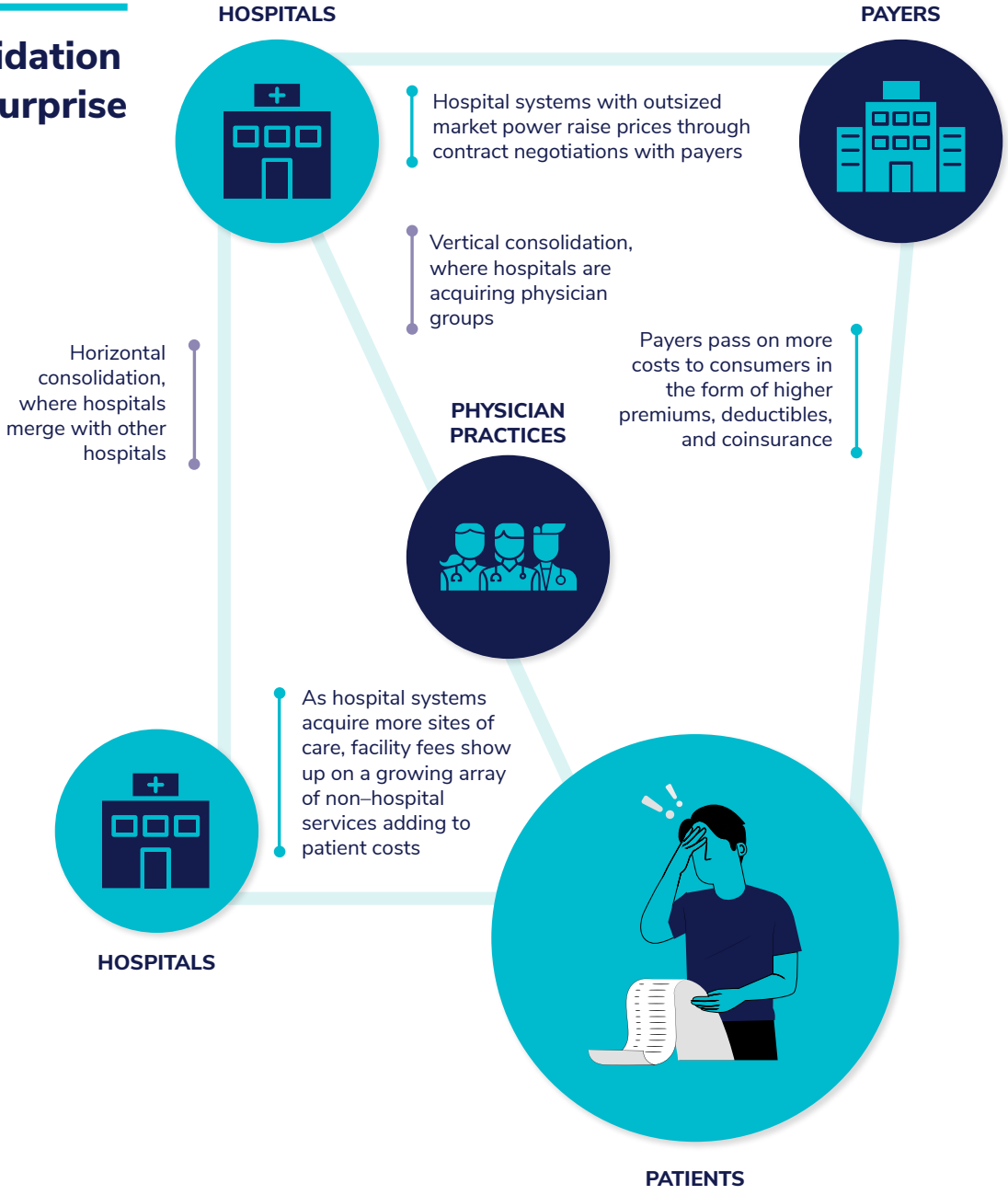
The COVID-19 pandemic accelerated hospital acquisitions, with hospitals and other corporate entities acquiring 36,200 additional physician practices from 2019 to 2021

PAI-Avalere Report on National Physician Employment Trends 2019-21

Provider consolidation is exposing more and more consumers to facility fees

The rise of hospital mergers since 1998 has led to 2,000 fewer hospitals operating in the United States.[6] In addition, the amount of hospitals that own office-based physician practices is increasing.[7] Even for primary care, practices are far less likely to be independent; in 2021, 54.1% of primary care physicians were employed by a hospital.[8] **More consolidated provider markets means that it is harder for consumers to find independent medical practices not tethered to a larger hospital system. This has real consequences for people's ability to access and afford needed care: prices are going up and unexpected facility fees are being charged for otherwise routine services.**

Provider Consolidation Leads to More Surprise Facility Fees for Patients



Multiple studies have found that hospital prices go up after hospitals merge and competition decreases.[9]

When hospital systems consolidate and acquire independent provider practices, their market power becomes larger and more concentrated. Because of this, hospitals are in a better bargaining position when it comes to setting rates with payers. This monopolistic bargaining power directly impacts the costs people pay for care because it means hospitals can unilaterally increase their rates, and payers have little choice but to accept them, or they risk having no hospitals in their provider network. Because of state and federal provider network adequacy requirements, some plans may only have the choice to take the inflated risk or be unable to operate at all. Multiple studies have found that hospital prices go up after hospitals merge and competition decreases.[9] A study of California's individual market found that increased vertical integration – in which hospital systems acquire physician groups – resulted in a 12% increase in marketplace premiums from 2013 to 2016.[10] Similarly, when hospital systems acquire physician practice groups, the cost of care provided in those hospital outpatient settings also goes up.[11]

Despite hospital claims to the contrary, hospital mergers and acquisitions of provider practices do not lead to more accessible or higher quality care for patients.[12] Price increases post-merger and acquisition are greater in commercial insurance, where there is less regulatory authority to rein in prices than there is in Medicare and Medicaid. Some of these price increases are a direct result of outsized market power of large hospital systems as competition decreases, allowing these systems to extract larger price concessions, especially from commercial payers.[13]

The ability of hospital systems to charge facility fees for a greater number of services and settings after the system acquires a provider practice is yet another symptom of monopolistic pricing practices.[14] Acquisition of outpatient practices, such as primary care offices, is driving exposure to facility fees that can often come as a shock to consumers. As costs go up for employers and insurance plans, consumers may experience greater cost-sharing in the form of higher deductibles and coinsurance.[15] The economic hardship is further pronounced for uninsured people who must bear the brunt of facility fees, usually in addition to the full cost of care. Hospitals may have financial assistance programs that help reduce costs for uninsured individuals, but these vary by hospital and can be difficult for consumers to navigate.

A backdrop to the acceleration of hospital mergers and acquisitions is the growing role of private equity firms in these business deals. Private equity acquisitions of U.S. physician practices have grown astronomically, rising sixfold from 2012 to 2021.[16] Private equity investments can offer short-term financial benefits to hospital and provider systems, but these ventures are often structured to prioritize short-term revenue generation and may not adequately support people's access to sustainable, equitable, and accessible hospital and provider systems in the long-term.[17] Despite claims that private equity investments will bring financial sustainability and efficiency to health systems, many private equity firms are entering into risky financial deals with acquired hospitals in the pursuit of quick profits, which in turn has caused hospitals to cut services and even declare bankruptcy.[18] These closures and bankruptcies following private equity acquisition are disproportionately impacting communities already experiencing inequitable access to services, including rural areas and low-income areas.[19] In response to a spate of hospital financial crises related to private equity acquisitions, the Federal Trade Commission, the U.S. Department of Justice's Antitrust Division, and the U.S. Department of Health and Human Services launched a cross-government inquiry in 2024 looking into private equity's role in and its increasing control over health care.[20]

Facility fees are an egregious example of inequitable pricing practices

It is difficult to disentangle many of these larger health care trends as hospital mergers and acquisitions of provider practices increase. Facility fees are only one symptom of all the out-of-control increases in hospital prices and monopolistic bargaining tools hospitals have with payers. Private equity is also driving hospital pricing increases while destabilizing the financial sustainability of entire hospital systems. Stuck in the middle of all of these pricing and market dynamics are consumers, who are hit with higher premiums, deductibles, and coinsurance.

There is a clear need to address the root causes of high prices, but facility fees are worth additional, separate examination for three reasons:

1. Because hospital facility fees are charged separately from the professional service, they may not be subject to the same plan design requirements, such as caps on annual out-of-pocket costs, meant to protect consumers from high cost-sharing. In some instances, facility fees may not be covered by insurance at all.
2. The way in which facility fees are being levied on consumers, often for routine services or in settings outside of a hospital, is frequently divorced from the reasons they are claimed to be charged for, which is said to support the unique role that hospitals play in providing infrastructure for unpredictable and high-cost care.
3. Facility fees are disproportionately harming marginalized communities.

Policy interventions that target facility fees will not solve the entirety of hospital pricing and affordability challenges, but may mitigate harm for consumers, particularly those more likely to struggle with unaffordable care. This includes populations facing persistent structural barriers to prevention and care access, such as communities of color (particularly Black and Hispanic or Latino communities), low-income communities, rural communities, and individuals with high health care utilization as a result of a chronic or complex condition.

Facility Fees Have a Disproportionate Impact on Marginalized Communities

The same systemic inequities and structural barriers to health that drive health disparities by race and ethnicity, income, insurance status and source of coverage, geography, and health status also drive consumers' outsized exposure to facility fees.

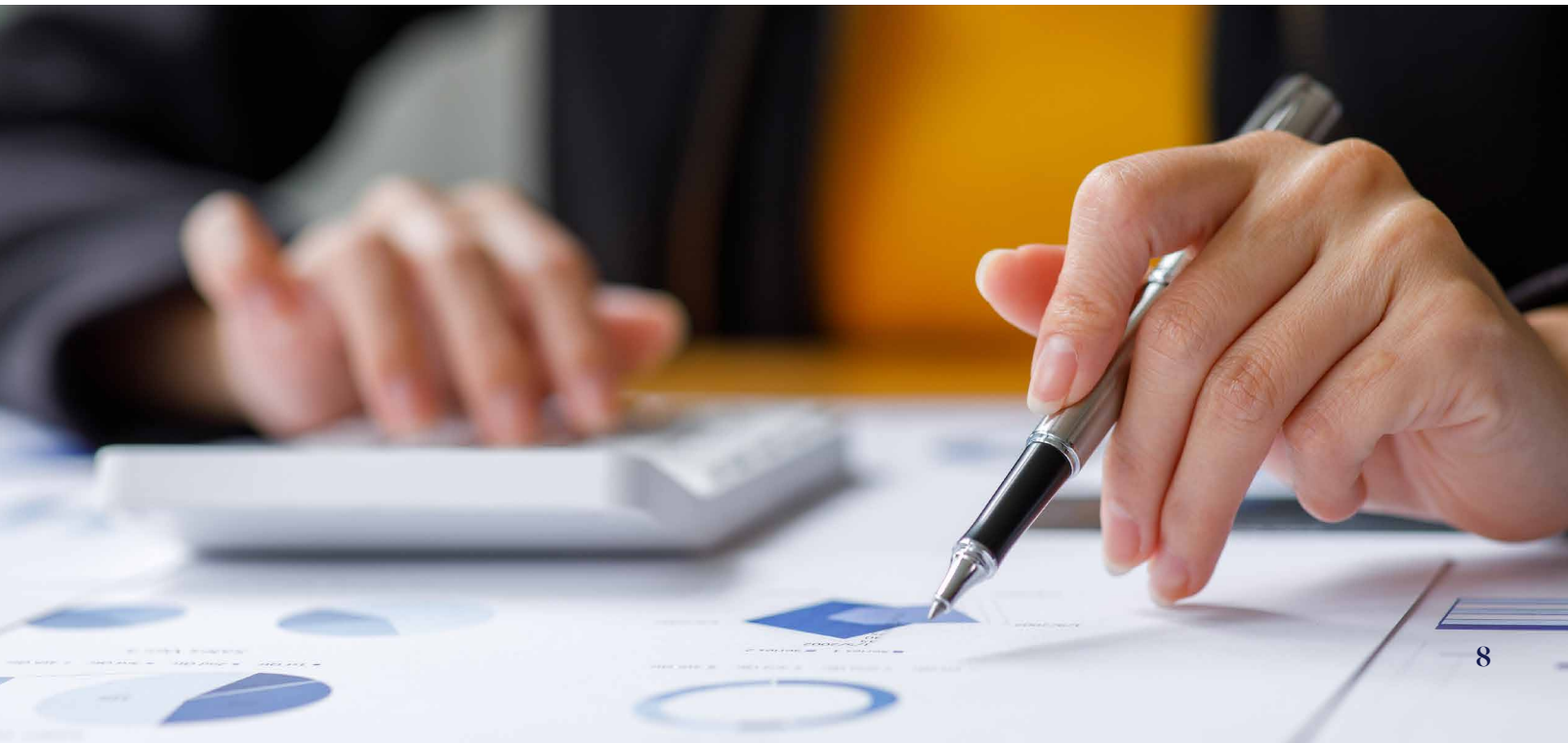
Communities of color and individuals with lower incomes

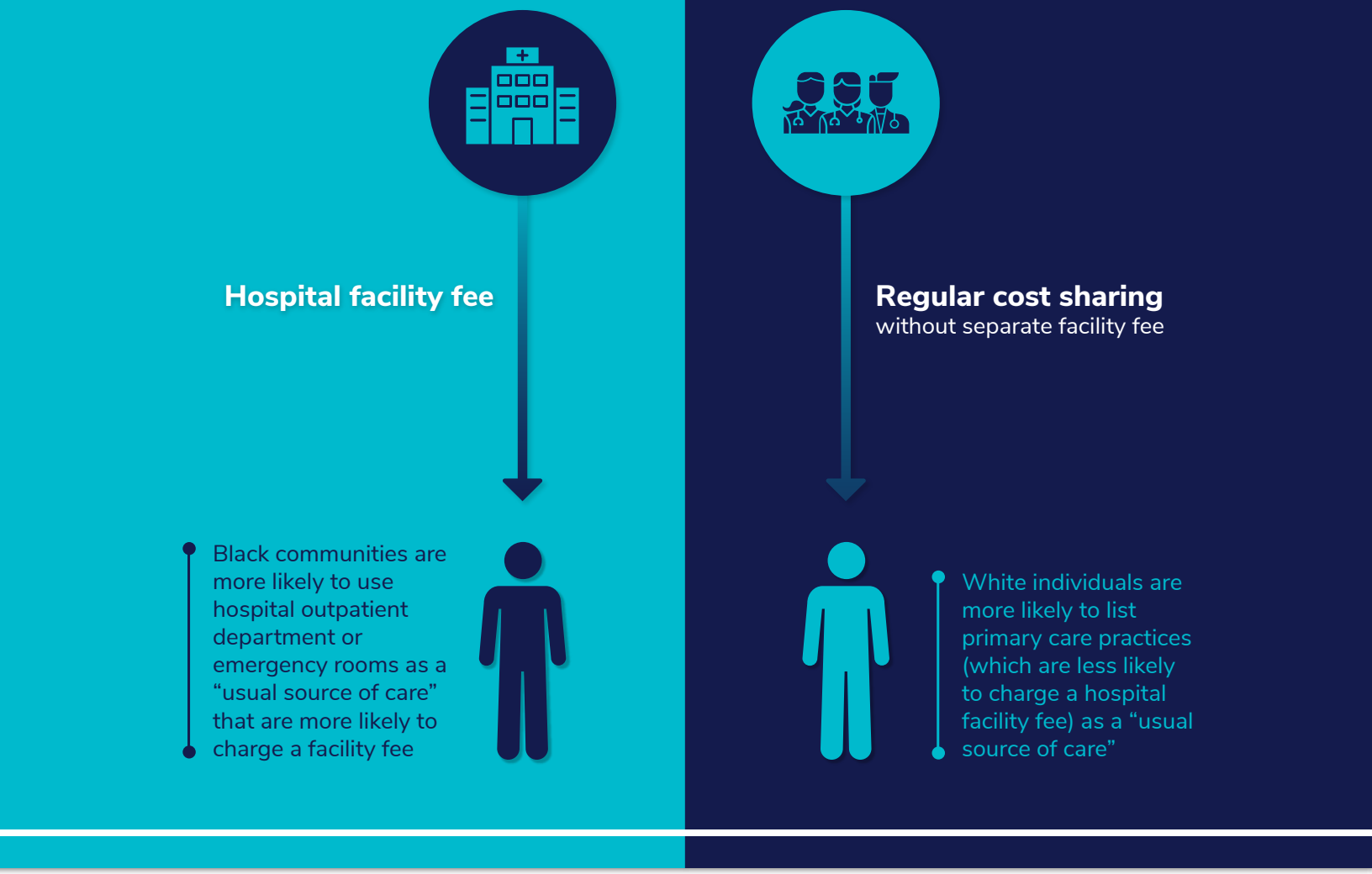
It is impossible to separate the growing medical debt crisis from rising hospital prices, including facility fees. A 2022 consumer survey found that 41% of adults in the United States have some medical debt (defined as any money they currently owe or debt they have due to medical or dental bills for their own medical or dental care or someone else's care).[21]

Unaffordable hospital prices are a chief driver of this growing medical debt crisis. One analysis based on nationally representative survey data found that of the adults who had some past due medical debt, nearly three in four owed at least some of that debt to hospitals, including 27.9% owing hospitals only and 45.1% owing both hospitals and other providers. Hospital-related medical debt is not only more prevalent, it's also more expensive. Adults with past-due hospital bills generally have much higher total amounts of debt (over a quarter of those with hospital-related medical debt had debts over $5,000) than those with past-due bills only owed to non-hospital providers.[22]

Evidence demonstrates that medical debt has a particular disproportionate impact among communities historically marginalized by the U.S. health care system:

- 56% of Black and Hispanic or Latino respondents had medical debt in 2022, compared to 37% of white adults.[22]
- Adults with lower levels of education and income are more likely than those with higher levels of education and higher incomes to say they had health care debt due to medical or dental bills in 2022.[21]
- In 2022, half of consumers without a college degree reported that they have health care debt compared to about three in ten college graduates.[22] More than half (57%) of adults with household incomes under $40,000 report that they currently have debt due to medical or dental bills.[23]





There is also evidence to suggest that structural barriers to care impact both service utilization and site of care and that these disparities disproportionately expose certain communities to hospital facility fees, particularly Black and Hispanic or Latino individuals. Survey data indicate that Black and Hispanic or Latino individuals are less likely to have a regular primary care doctor than white individuals.[24] Multiple studies have also found that Black people are more likely to use hospital outpatient departments or emergency departments as a usual source of care (as opposed to primary care practices) than their white counterparts.[25] This utilization difference disproportionately exposes Black people to facility fees attached to hospital or hospital affiliated sites of care, even for routine services.

In addition to differences in usual sources of care, there is substantial evidence that hospital use due to lack of access to routine care disproportionately affects certain racial and ethnic groups.[26] Connecticut used hospital inpatient discharge data to quantify the disparities in hospital charges among Black and Hispanic or Latino Connecticut residents compared with non-Hispanic white residents.[27] **The state found that the mean hospital charges for white Connecticut residents were $1,409 lower than for Black residents and $1,017 lower than for Latino or Hispanic residents. They found that the total excess hospital charges due to racial and ethnic disparities in a single year was $88 million.** While inpatient hospitalizations may not be appropriate for elimination of facility fees, it is important to fully understand disproportionate hospital cost exposure for certain communities as facility fee reforms are developed.

The connection between racism, health status, and hospital-related medical debt culminates in a cruel cycle. For Black people, institutional racism and systemic barriers to health and wellness contribute to a higher prevalence of avoidable chronic conditions. Chronic conditions that are not appropriately treated can lead to otherwise avoidable hospital use and unchecked hospital prices and facility fees exacerbate disproportionate medical debt burden. In turn, medical debt contributes to worse health outcomes.[28]

Disparities based on presence of chronic and complex condition

People with chronic and complex conditions who have greater health care needs tend to be most exposed to affordability gaps and underinsurance, and are already hit harder by rising health care prices, including facility fees. For example, someone with a complex or chronic condition, such as a cancer diagnosis, will have far more exposure to facility fees by virtue of increased touch points with the health care system as they navigate lab work, specialist visits, and hospital stays.[29] However, when a hospital facility fee is attached to services that do not necessarily need to be provided in a hospital setting, it becomes a junk fee that disproportionately harms people with chronic and complex conditions.

An actuarial analysis commissioned by the Leukemia & Lymphoma Society (LLS) found striking price variation by site of care in both Medicare and commercial payers for eight disease groups: breast cancer, colitis, chronic obstructive pulmonary disease (COPD), Crohn's disease, multiple myeloma, multiple sclerosis, non-Hodgkin lymphoma, and rheumatoid arthritis.[30] The same services received in hospital outpatient settings were far more expensive than when received in a physician office setting, resulting in much higher consumer costs depending on where someone received care. While these price differences are separate from facility fees, they are a symptom of the same problem: hospitals are hiking up prices in outpatient settings to offset hospital operational costs, leading to higher consumer costs. The report included analysis of pricing data across three sites of service: on-campus hospital outpatient, off-campus hospital outpatient, and office settings, using 66 procedures that had previously been identified by MedPAC[31] that can be provided safely in any of these three sites. One example of the price differences found by LLS is included in the table below and shows the added financial burden that cancer patients face in on- or off-campus outpatient hospital settings as opposed to office visits.

Another analysis of large- and small-group commercial claims data from 2019 found similar results, finding that chemotherapy was nearly three times more expensive when provided in a hospital outpatient setting as opposed to an independent physician office.[32] These price discrepancies have a significant impact on patients accessing cancer care, considering that in 2021, a majority of chemotherapy visits for Medicare patients were billed by hospital outpatient departments.[33] There is also no evidence to suggest that the quality of this care varies based on setting, making the price discrepancies even more disturbing.

Rural disparities

People in rural areas are more likely to lack health insurance coverage, have fewer provider choices, and are more likely to be older and have more health care needs than people who live in urban areas – all factors that may also expose them more to facility fees.[34] Still, the impact of facility fees on patients living in rural areas is harder to discern. The average impact of differential prices by site of care was more significant for rural Medicare patients than for urban patients; however, for patients with commercial insurance, the analysis showed the opposite was true, finding that the average impact of differential prices by site of care was more significant in urban than in rural areas.[35] This difference can be attributed to contracting differences between hospitals and payers within the commercial and Medicare markets.

Hospitals are adamant that payment reforms that remove the ability to charge facility fees on the range of services referenced in the MedPAC report for either Medicare or commercial insurance would be devastating for rural hospitals.[36] However, hospitals have shown very little data and evidence supporting the notion that facility fees are being reinvested into rural hospital infrastructure, or any specific community that experiences inequitable access to services. While it is important to ensure that hospitals that serve rural communities are able to remain financially viable, unfair facility fees attached to outpatient services are not the way to achieve this goal.

Average Unit Cost for Commercial Breast Cancer Beneficiary

(Risk Score Cohort >2.0 and <5.0)

CPT Code	CPT Definition	*On–Campus* Outpatient Hospital	*Off–Campus* Outpatient Hospital	Office
77412	Radiation treatment delivery, complex	$4,274	$3,088	$542
96413	Infusion of chemotherapy into a vein up to 1 hour	$1,818	$1,802	$758

Source: Leukemia & Lymphoma Society, "Site Neutral Payment Reform Has the Potential to Significantly Reduce Out-of-Pocket Patient Spend," November 2023

Summary of State and Federal Policy Recommendations

There are a number of policy reforms that could eliminate or mitigate the harm unregulated facility fees are causing consumers. Truly solving hospital affordability challenges must include broader policy reforms to address the underlying drivers of rising costs, including provider consolidation, private equity ownership of health care providers, and monopolistic hospital pricing practices. This broader lens is particularly important in the context of facility fee reform, because without attention to other hospital pricing and cost dynamics, reducing facility fees could result in hospitals shifting those same costs to their procedure prices. However, there are still more incremental reforms that policymakers can take to remove the burden of hospital facility fees for consumers who are disproportionately harmed by them.

The policies below include priorities that are applicable at both the federal and state levels:

1 Policymakers should impose site, service, and billing specific limits on the use of hospital facility fees, using an equity lens to identify specific limits.

An important way to protect patients from surprise and unfair facility fees is to limit the circumstances under which hospitals can charge them. While Congress has the ultimate authority to make changes to Medicare payment structures, state legislatures also have significant abilities to prohibit or limit hospitals from charging facility fees.[37]

There are three policy paths for limiting facility fees:

Service-specific limits

Identifying the services that are attenuated from emergency, inpatient, highly specialized, or unexpected care and prohibiting facility fees for these services is the most expansive way to protect patients from inappropriate facility fees. This approach is agnostic to the site of service and instead focuses on the types of services that do not require additional facility-based resources. For instance, evaluation and management services, which are typically used for routine care, should not have facility fees attached to them because they do not involve intensive hospital resources.[38] Attaching facility fees to routine and preventive services can serve as a disincentive to access.

Identifying the services that should not be subject to facility fees is complex. Any analysis should include the impact on specific populations, assessing the services that do not require intensive hospital resources disproportionately used by particular communities. For example, several state departments of insurance have identified diabetes and COPD as conditions that have disproportionate impacts on Black communities and have prioritized these conditions for equity-enhancing plan design features in the individual and small group markets.[39] This initiative could be expanded to include the services associated with these conditions and limits on use of facility fees for these particular services regardless of the site of care.

Site-specific limits

Policymakers should also consider limiting the sites of care in which facility fees can be charged.[40] This approach recognizes the role that provider consolidation plays in expanding the footprint of hospital services and the hospital-affiliated outpatient settings in which facility fees are being levied. For instance, outpatient hospital departments that are often not located on a hospital campus – or even close to a hospital campus – and do not benefit from or use the resources of a large hospital building could be identified as sites where hospitals are prohibited from charging facility fees. An equity lens should be used to identify these sites of care, assessing data about usual sources of care based on race and ethnicity, income, payer source, or disease state.

> *Starting July 1, 2024 Connecticut law prohibits hospitals from charging facility fees for evaluation and management services and assessment and management services provided in hospital on and off-campus settings outside of the emergency department.*
>
> **Connecticut Substitute House Bill No. 6669**

Billing-specific limits

Policymakers should also consider establishing restrictions on how hospitals bill, such as prohibiting the use of "institutional provider forms" at specific locations. An institutional provider form is a specific billing form used by hospitals for reimbursement, but they are increasingly being used for billing for procedures performed in sites outside of a hospital setting. These types of billing requirements allow policymakers to limit the reach of facility fees.

2 Regulators should require hospitals to report data on facility fees

Details on how facility fees operate, including the types and scope of outpatient clinics and providers that hospitals are attaching these fees to, are difficult to track. This lack of comprehensive data makes it very challenging to fully understand how facility fees disproportionately impact specific communities, especially those historically marginalized by the U.S. health care system.

There are a number of technical issues that must be addressed in conjunction with data reporting mandates. For instance, over the course of its work to study hospital facility fees in Colorado, the Hospital Facility Fee Steering Committee identified a major data gap in the state's All Payer Claims Database. The Committee noted that because there is no flag or indicator for facility fees, these fees are very difficult to identify and trace back to a particular hospital.[41] Similarly, requiring providers to register with national or state databases is one way that regulators could better monitor the settings and services in which facility fees are being charged. In conjunction with any reporting requirements, regulators should collaborate with hospitals to develop workable solutions to update facility fee data reporting systems and procedures.

Policymakers should pass legislation mandating that state and federal health care agencies work with stakeholders to evaluate the impact of facility fees on patients, the health care system, and health care prices more generally. Data compiled from these reports should:

- Be publicly available in an easy-to-understand format and guide future legislative or regulatory initiatives to address facility fees.
- Be standardized and aggregated to protect patient privacy and safety while also complying with existing federal hospital data collection requirements.[42]
- Include a wide collection of hospital-submitted data points, which may include, but are not limited to, a list of system-affiliated entities that charge facility fees, a listing of medical procedures subject to facility fees, the total revenue generated by facility fees, and the amount of cost-sharing people experience related to facility fees.

MedPAC Site Neutrality Recommendations

In its June 2023[44] report, the Medicare Payment and Access Commission (MedPAC) recommended the federal government adopt a site neutral payment policy for Medicare.

- MedPAC identified 66 procedures that are safely and commonly provided in office-based practices and ambulatory surgical centers (ASCs) and found significant discrepancies in prices for these services, with hospital outpatient departments (HOPDs) levying facility fees that hike up the price considerably.
- MedPAC recommended that Congress align payments to HOPDs and ASCs with the physician fee schedule for 57 procedures and recommended aligning HOPD payment rates with rates paid in ASC settings for the remaining nine procedures.

Starting November 1, 2024 Indiana law prohibits hospitals from billing for services provided in hospital outpatient settings owned by the hospital as if they were provided in the hospital's main campus

Indiana House Bill 1004

3 Facility fees should be transparently disclosed in patient notices

Many patients are caught off guard when they receive a facility fee, especially for a service incurred in a setting outside of a hospital. While transparency requirements will not help to mitigate the affordability challenges these fees present, they can at least help ensure patients are aware of charges before they are billed.

Policymakers should consider:

- Requiring providers that charge facility fees to disclose the estimated costs of the fee at the time the appointment is made, in the language that is preferred by the patient.
- Increasing transparency through mandatory, clearly accessible notices inside the facility (for example, in waiting rooms or at check-in desks) that is owned by a health system and may charge a facility fee.

Maryland Facility Fee Disclosure (Md. Code, Health-Gen. § 19-349.2)

a. Your appointment with (provider, practice, or clinic name) will take place in an outpatient department of (hospital name).

b. (Hospital name) will charge an outpatient facility fee that is separate from and in addition to the bill you will receive from (provider).

c. You will receive two charges for your visit:
1. A provider services bill from (provider); and
2. A hospital facility bill from (hospital name).

Expected Fee

(if known) The amount of the facility fee that will be charged by (hospital name) for your appointment is $_____ or

(if unknown) (Hospital name's) facility fee is likely to range from $_____ to $_____, or

(if unknown) Based on appointments like the one you are scheduled for, we estimate the facility fee to be $_____.

(if unknown) We are providing you with a range of fees and an estimate because the actual amount of the facility fee will depend on the hospital services that are actually provided. The fee could be higher if you require services during your appointment that we cannot reasonably predict today.

Financial help for your portion of the outpatient facility fee bill may be available. If you need financial help with the outpatient facility bill, please contact (hospital financial assistance office, with telephone number and direct website address).

Receiving services here may result in greater financial liability that receiving services at a location where a facility fee may not be charged.

4 Policymakers should ensure that facility fee protections and data requirements are adequately enforced

Policies that limit facility fees, impose data reporting requirements on hospitals, or require notice and disclosure requirements are only as strong as their enforcement mechanisms. Any policy to restrict facility fees must include:

- Prohibiting insurers from paying facility fees or imposing monetary penalties on hospitals that fail to adhere to prohibitions.
- Labeling any effort by a hospital to circumvent facility fee protections found in law as an unfair or deceptive trade practice subject to civil penalties.
- Establishing a course of action through the state attorney general's office for people to contest charges they may have been unfairly billed.

5 Policymakers should invest in research that evaluates the health equity implications of hospital facility fees

Despite the heightened scrutiny on hospital facility fees and the harm these fees are causing patients, there is very little analysis of how these fees are contributing to health disparities across marginalized and disenfranchised communities. As state and federal government agencies convene task forces and advisory committees to assess this issue, there must be more attention paid to the types of data sources and analyses needed to show how facility fees are disproportionately impacting communities historically marginalized by the U.S. health care system, including but not limited to its impacts on race and ethnicity, income, presence of a complex or chronic condition, and geography. Given the gaps in facility fee datasets mentioned above, it may be necessary to stratify data across multiple datasets, including hospital claims data and social determinants of health data.

The Centers for Disease Control and Prevention (CDC) has developed a social vulnerability index to track the social vulnerability of every census tract.[43] This index measures 16 social factors, including poverty, lack of vehicle access, crowded housing, and race and ethnicity. Overlaying facility fee data with adapted social vulnerability indices would help to articulate how these facility fees compound systemic inequalities.

Conclusion

Restricting consumers' exposure to facility fees and pushing for policy reforms that take health equity into account will take federal and state leadership. Policymakers should assess any policy under consideration for the extent to which it will address the outsized harm facility fees have on communities based on race and ethnicity, income, geography, and presence of a chronic or complex condition.

Endnotes

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